

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155162		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		(X3) DATE SURVEY COMPLETED 08/18/2011	
NAME OF PROVIDER OR SUPPLIER  AUTUMN RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN46992			
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint # IN00094459.</p> <p>Complaint #IN00094459 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 15,16,17, &amp; 18, 2011</p> <p>Facility number: 000081 Provider number: 155162 AIM number: 100289570</p> <p>Survey team: Vicki Bickel, RN-TC Debora Barth, RN Deanne Mankell, RN</p> <p>Census bed type: SNF/NF: 45 Total: 45</p> <p>Census payor type: Medicare: 9 Medicaid: 26 Other: 10 Total: 45</p> <p>Sample: 12 Supplemental sample: 2</p>			F0000	<p>The creation and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after September 17, 2011. We respectfully request a desk review in lieu of a post survey revisit.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0323 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on August 23, 2011 by Bev Faulkner, RN</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to assure the environment was free from accident hazards related to chemicals stored in an unlocked cabinet and the door to the oxygen room found unlocked. This potentially affected 3 of 32 residents living on the 3rd floor who were independently mobile with cognitive impairments.</p> <p>Findings include:</p> <p>The following observations were made during the environmental tour on 8/17/11 from 9:00 a.m. to 10:50 a.m.</p> <p>1. The bathroom on the third floor of the facility had an open cabinet. The cabinet contained two spray bottles of "Neutral Quat Disinfectant." The solution was</p>			F0323	<p>To ensure the environment is free from hazards. For 3 residents on 3 rd floor, the cabinet was immediately locked upon discovery of opened cabinet containing disinfectant. Staff was inserviced on keeping chemicals locked up in cabinet preventing accidents and hazards by DNS and ADNS. All residents on 3 rd floor will no longer have the potential to be affected by an unlocked cabinet containing disinfectant due to an automatic door closure and keyed locked installed on shower room door. All shower rooms will have automatic door closures and keyed locks installed on shower room doors. Environmental and Safety CQI will be completed to ensure all shower rooms will have automatic door closures and keyed locks installed on shower room doors and checked for functioning by maintenance. Staff</p>		09/17/2011

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	<p>identified by the Housekeeping Supervisor as being used to sanitize nonporous surfaces such as shower chairs after resident use.</p> <p>The Material Safety Data Sheet for the solution was presented by the Housekeeping Supervisor on 8/17/11 at 1:30 p.m. The hazards identified for the solution included: "Corrosive to eyes. Causes eye burns and skin irritation. Harmful or fatal if swallowed." The Housekeeping Supervisor immediately closed and locked the cabinet doors.</p> <p>2. The Oxygen storage room was located just south of the elevator doors. The door to it was unlocked and ajar. Three large canisters of liquid oxygen were in the room. There was no staff in the area. The Housekeeping Supervisor closed the door which caused it to lock.</p> <p>During the entrance tour, on 8/15/11 from 9:30 a.m. to 10:45 a.m., with the Assistant Director of Nursing, 3 of 32 residents living on the third floor were identified as independently mobile and confused.</p> <p>3.1-45(a)(1)</p>				<p>inserviced on keeping chemicals locked up in cabinet preventing accidents and hazards and use of keyed locks by DNS and ADNS. Environmental and Safety CQI will be completed to ensure all shower rooms will have automatic door closures and keyed locks installed on shower room doors and for functioning by maintenance weekly for 4 weeks then monthly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed if not met by CQI team. All staff inserviced by maintenance on storage of chemicals and use of keyed locks. Pre and post tests provided. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. September 17, 2011</p> <p>To ensure environment is free from hazards. For 3 residents on 3 rd floor, the O2 door was immediately closed which caused it to lock. Staff inserviced by DNS about storage of chemicals and locking of the O2 storage room doors. Door was repaired immediately to ensure self closure by maintenance.</p> <p>All residents on 3 rd floor will not have the potential to be affected by the ajar door due to the repair of the automatic door closure on the door by maintenance.</p> <p>All O2 storage room doors will have</p>		

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					<p>automatic door closures inspected to ensure proper function by maintenance. Environmental and Safety CQI will be completed to ensure all O2 rooms will have functioning automatic door closures. All staff inserviced by maintenance on locking of O2 storage room doors.</p> <p>Environmental Safety CQI will be completed by maintenance to ensure all O2 storage room doors will have automatic door closures inspected to ensure proper functioning 5 times weekly for 4 weeks then weekly for 4 weeks then monthly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed if not met by CQI team. All staff inserviced by maintenance on locking of O2 storage room doors with pre and post tests. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance.</p> <p>September 17, 2011</p>		

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F0431 SS=D	<p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on record review, observation and interview, the facility failed to ensure 1 over-the-counter (OTC) medication was labeled for 1 (Resident #9) of 10 residents observed during the medication administration pass.</p> <p>Findings included:</p>			F0431	<p>To ensure proper medication labeling. RN immediately labeled resident #9's over the counter medication with physicians name and room number. Medication was already labeled with name and expiration date. Licensed nurses was inserviced by DNS and ADNS on proper labeling of over the counter medications.</p>		09/17/2011

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	<p>Resident #9's record was reviewed on 8/15/11 at 10:45 a.m. Diagnoses included, but were not limited to: hypertension, dementia and anxiety.</p> <p>The medication administration pass was observed on 8/16/11 at 11:20 a.m.</p> <p>Licensed Practical Nurse (LPN) #5 was preparing to give an over the counter medication (OTC) to Resident #9. The physician's order was for Tylenol 500 mg every 6 hours. The LPN retrieved the medication from the med cart and indicated there was no label on the bottle of pills. She left to go talk with the Director of Nursing. When she returned, she indicated the bottle should have been labeled with the resident's name, date opened and physician's name. The OTC administration was not observed.</p> <p>An interview with the Director of Nursing on 8/16/11 at 11:30 a.m., indicated the OTC medication should have been labeled at least with the resident's name and date opened.</p> <p>3.1-25(j) 3.1-25(l)(1) 3.1-25(l)(2)</p>				<p>All over the medications in all med carts was audited to ensure appropriate labeling. No other residents were affected.</p> <p>On 08/16/2011, a protocol for medication labeling for over the counter meds was developed and provided to the surveyor by DNS. Licensed nurses were inserviced immediately by DNS and ADNS on proper over the counter medication labeling. Protocol was posted in prominent work areas to ensure availability to all nurses.</p> <p>CQI medication storage review and auditing of medication carts will be completed weekly for 4 weeks then monthly for 3 months then quarterly thereafter by DNS or DNS Designee. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed if not met by CQI team. Licensed nursing staff inserviced by DNS and ADNS on proper labeling of over the counter medications with pre and post tests. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance.</p> <p>September 17, 2011</p>		

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F0441 SS=E	<p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure staff practiced infection control procedures</p>			F0441	To ensure infection control practices with handwashing. CNA #1 was individually counseled on appropriate glove use and		09/17/2011

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	<p>related to hand washing, catheter care, contact isolation and tracheostomy care. This affected 4 of 12 sampled residents ( Residents # 9, # 18, # 16, and # 43 and involved facility staff (CNA #1, Physical Therapist # 3, and LPN #4)</p> <p>Findings include:</p> <p>1. The perineal care was observed for Resident # 9 on 8/15/11 at 11:00 a.m. CNA # 1 and LPN # 2 provided the care. Resident # 9 was assisted off the toilet after having had a bowel movement. The CNA cleansed the resident's rectal area while wearing gloves. Then without removing the gloves and washing her hands, the CNA proceeded to assist the resident to pull up his shorts. She then assisted the resident into the room. While the LPN held the resident steady, the CNA pulled the privacy curtain while still wearing the contaminated gloves. The resident was observed for open areas on his buttocks and his clothes replaced. The CNA was still wearing the same gloves as she assisted the resident. She then assisted the resident into a wheel chair and repositioned him. She then removed her gloves and washed her hands.</p> <p>The facility policy for handwashing was obtained from the Assistant Director of</p>				<p>handwashing by DNS. 13 residents had the potential to be affected by the deficient practice. All staff inserviced on infection control, glove use, and handwashing by DNS and ADNS. Staff inservicing on infection control, glove use, and handwashing by DNS and ADNS or designee will be provided monthly at inservices with pre and post tests. Infection control CQI, which includes observations of direct care staff providing care to the residents on all shifts, will be completed by a nursing manager or designee, weekly for 4 weeks then monthly for 3 months then quarterly thereafter. Staff will be inserviced monthly on infection control, glove use, and handwashing by DNS and ADNS, or designee, with pre and post tests. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed if not met by CQI team. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. September 17, 2011 To ensure infection control practices with catheter tubing Resident #18 was immediately educated on importance of keeping catheter and tubing off the floor. Resident provided risk vs. benefits of proper storage and positioning of catheter bag. Catheter bag and tubing was placed in a basin on the floor. All other residents with indwelling catheters were</p>		

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	<p>Nursing (ADON) on 8/17/11 at 3:45 p.m. The policy/procedure indicated the following: "....C. 3. When washing hands with soap and water, wet hands first with water, apply soap and rub hands together vigorously for at least 20 seconds.... covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet....D. 4. Decontaminate hands before donning gloves (clean or sterile) *this includes the changing of gloves in the middle of any procedure. 5. Decontaminate hands if moving from a contaminated-body site to a clean body site during patient care...."</p>				<p>reviewed to ensure catheter bags and tubing were positioned appropriately not touching the floor. Nursing staff inserviced on proper positioning and storage of catheters by DNS and ADNS. Resident was provided information on risks and benefits of proper positioning and storage of catheter bag and tubing by DNS and ADNS. Catheter bag was placed in a basin to keep tubing and bag from touching the floor. Resident #18's foley catheter was discontinued on 08/22/2011. Catheter CQI will be completed weekly by DNS or Designee for 4 weeks then monthly for 3 months then quarterly thereafter. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed if not met by CQI team. All staff inserviced by DNS and ADNS on proper storage and positioning of catheter. Pre and post tests provided. Resident #18 foley catheter was discontinued on 08/22/2011. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. September 17, 2011 To ensure infection control practices with contact isolation and handwashing. Contract therapist was immediately educated by DNS about contact isolation protocol and handwashing. Staff was immediately inserviced by DNS on contact isolation procedures</p>		

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					<p>and handwashing. Contract therapist was immediately removed from patient care and suspended. Contract therapy company was notified . Documentation obtained to ensure contract therapist received pre employment training in regards to contact isolation and handwashing practices. Housekeeping disinfected surfaces. Contract therapist removed from providing services at the facility. No other residents had the potential to be affected. Resident #16 was the only resident in contact isolation. Statement provided by contract therapist that resident #16 was last resident treated and washed hands immediately upon entering therapy room. Inservice all staff on contact isolation precautions and handwashing by DNS and ADNS. Infection control CQI, which includes observations of direct care staff providing care to the residents on all shifts, will be completed by a manager or designee weekly for 4 weeks then monthly for 3 months then quarterly thereafter. All staff inservice on contact isolation protocol and handwashing with pre and post tests. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed if not met by CQI team. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance.</p>		

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					September 17, 2011 To ensure proper tracheostomy care techniques to resident #43. LPN #4 was retrained per DNS on tracheostomy care, infection control, and suctioning. All residents with a tracheostomy has a potential to be affected. LPN #4 was retrained per DNS on infection control, tracheostomy care and suctioning on 08/17/2011. Licensed respiratory therapist inserviced licensed nurses on tracheostomy care and suctioning at resident #43's bedside on 08/16/2011. All licensed nurses will be retrained by DNS and ADNS on September 8, 2011 for tracheostomy care and infection control with pre and post tests. Infection control and tracheostomy care CQI, which includes observing direct care staff providing tracheostomy care to the residents on all shifts, will be completed weekly for 4 weeks then monthly for 3 months then quarterly thereafter by DNS or Designee. CQI will be reviewed after 6 months to ensure threshold, and will be reviewed if not met by CQI team. All licensed nurses will be retrained on tracheostomy care and infection control by DNS and ADNS with pre and post tests. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance. September 17, 2011		

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	<p>2. Resident # 18 record was reviewed on 8/17/11 at 2:00 p.m. Diagnosis included but were not limited to: obesity, peripheral vascular disease, hypertension, atrial fibrillation, and obstructive uropathy.</p> <p>The Minimum Data Set, dated 7/18/11, indicated the resident was not cognitively impaired.</p> <p>Resident # 18 was observed on 8/16/11 at 5:35 p.m., sitting in a chair in his room with the catheter bag hanging on the bottom rung of his walker. The bottom of the catheter bag was laying on the floor along with catheter tubing.</p> <p>An interview with Resident #18 was conducted on 8/16/11 at 5:36 p.m. The resident indicated he preferred not to have a privacy bag covering the catheter bag. He felt the privacy bag was too small and restricts urine flow into the catheter bag.</p> <p>On 8/17/11 at 11:17 a.m., Resident #18 was again observed sitting in his room with the catheter bag hanging on the walker with the bag and tubing laying on the floor.</p> <p>On 8/17/11 at 2:25 p.m., an interview with the resident indicated he preferred to leave the bag uncovered while in his</p>						

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	<p>room, but covers it when he leaves his room.</p> <p>An interview conducted with the resident on 8/18/11 at 8:45 a.m., indicated the resident was not sure if staff had discussed the increased risks for infection by having the bag and tubing on the floor.</p> <p>An interview conducted with the Director of Nursing (DoN) on 8/18/11 at 8:50 a.m., indicated that the Assistant Director of Nursing and herself have discussed with the resident about keeping the catheter bag and tubing off of the floor. She further indicated he was advised of the increased risks for infection. The DoN indicated there had not been any other devices tried to keep the catheter bag off the floor.</p> <p>3. Resident #16's record was reviewed on 8/15/11 at 11:05 a.m. Diagnoses included, but were not limited to: peripheral vascular disease, cerebral vascular disease, chronic obstructive pulmonary disease, urinary retention, and urinary tract infection with Vancomycin resistant enterococcus.</p> <p>Resident #16 was placed in contact isolation due to Vancomycin resistant enterococcus (VRE) in his urine, per facility protocol.</p>						

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	<p>On 8/17/11 at 11:15 a.m., Physical Therapist #3 was observed with the resident in his room. She was observed touching the resident on the shoulder and arm. The therapist had no personal protective equipment on (gown or gloves).</p> <p>The therapist was observed leaving the resident's room without washing her hands. An interview conducted with the therapist, at that time, indicated she was unsure if she needed gloves and/or gown for contact isolation. The therapist then left the hallway, without washing her hands.</p> <p>The therapist's schedule for 8/17/11 was received and reviewed on 8/17/11. The schedule indicated she was to see 14 residents.</p> <p>The facility policy, received and reviewed on 8/17/11, indicated "3. Wear latex gloves when entering the room before contact with the resident or environmental objects. Change gloves and wash hands after having direct contact with the resident...."</p> <p>4. Resident #43's record was reviewed on 8/18/11 at 9:20 a.m. Diagnoses included, but were not limited to:</p>						

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	<p>dementia, diabetes mellitus, respiratory insufficiency, aspiration pneumonia, and tracheostomy.</p> <p>An observation of tracheostomy care occurred on 8/17/11 at 2:55 p.m., with Licensed Practical Nurse (LPN) #4.</p> <p>The LPN had washed her hands and was preparing her supplies for the procedure on the overbed table. She opened the package containing the sterile supplies and placed the sterile drape on the table for her sterile working area. The sterile drape slipped and she placed her open hand on the right side of the drape to reposition it. The LPN continued preparing her work area.</p> <p>LPN #4 donned sterile gloves and moistened some of the sterile 4 x 4 gauze. She cleaned the resident's neck (under the tracheal tube security tie) with the moistened gauze. She cleaned from the left lateral side of the neck towards the tracheal stoma (opening) and then disposed of the gauze. She obtained more sterile moistened gauze and cleaned under the tie, from the right lateral side of the neck to the tracheal stoma.</p> <p>The facility policy received and reviewed on 8/17/11, indicated "dampen sterile applicators...and swab secretions from</p>						

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F9999	<p>area around tracheostomy..... Continue until trachea area is completely clean of secretions."</p> <p>3.1-18(b)(1) 3.1-18(l)</p> <p>STATE FINDINGS</p> <p>3.1-19 ENVIRONMENTAL AND PHYSICAL STANDARDS</p> <p>(u) The nurses' station must be equipped to receive resident calls through a communication system from the following: (3) Activity, dining, and therapy areas.</p> <p>This state rule was not met as evidenced by :</p> <p>Based on observation and interview, the facility failed to provide a call system from an activity lounge located at the west end of the secure unit. This potentially</p>			F9999	<p>To ensure a call system was in place on west end of the secure unit, hands bells was immediately placed on end tables for use. IEI was notified and service call was scheduled for 08/26/2011 to install call light. Staff and residents inserviced on use of hand bells by residents until installation of call light system by Memory Care Facilitator.</p> <p>13 residents residing on unit had the potential to be affected. Hand bells were placed in lounge area for use. Call light system was installed on 08/26/2011. Staff and residents inserviced on use of hand bells by residents and installation of call light system by Memory Care Facilitator.</p> <p>The facility conducted an audit for areas in the building lacking a call</p>		09/17/2011

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	<p>affected 13 of 13 residents living on the secure unit.</p> <p>Findings include:</p> <p>The west lounge on the secure unit was observed during the environmental tour on 8/17/11 at 10:30 a.m. There was no call light located in the lounge. The Housekeeping Supervisor was interviewed at the time. She indicated the lounge had recently been made into a resident area and no call light had been installed.</p> <p>Thirteen residents were noted to live on the secured unit.</p> <p>3.1-19(u)(3)</p>				<p>light system. Life Safety surveyed on 08/30/2011 and no other areas identified with deficient call light system. Staff inserviced on call light in west lounge on secure unit by Memory Care Facilitator. Call light system installed 08/26/2011.</p> <p>Environmental Safety CQI will be completed by maintenance or designee to ensure appropriate call systems are available to monitor for the need of appropriate call light installation weekly for 4 weeks then monthly for 3 months then quarterly thereafter.</p> <p>CQI will be reviewed after 6 months to ensure threshold, and will be reviewed if not met by CQI team. All staff inserviced on call light installation/system by Memory Care Facilitator with pre and post tests. The CQI team reviews the audits monthly and action plans are developed as needed to ensure continual compliance.</p> <p>September 17, 2011</p>		